

TEXAS PARTNERSHIP FOR FAMILY RECOVERY

MARKETING AND SUSTAINABILITY

First Principle: Never come to the table empty handed

Budgeting for, and funding of, an integrated services system or Family Drug Treatment Court will require close cooperation and ingenuity. Planning must include immediate, intermediate and long-term funding. For instance, local or state grant funds may be available to start a court. Such funds, however, generally are not permanent and, eventually, on-going local and state funds will be required. New dollars require either establishing a new tax or fee or the redirection of current funds from existing resources. A close analysis of local budgets, along with strategies to leverage or coordinate funds and services should be an on-going central piece of planning. Nationally, some local courts require the participant to pay a fee for participation in a drug court. Fees appear to be more commonly used in criminal drug courts than in family drug treatment courts.

At the state level, there are a range of federal funds that can cover services to address substance abuse and related disorders. (See Appendix L). However, the fact that a service type is allowable does not mean that the Texas legislative budget authorizes expenditure on the particular service or service category. Further, attention must be paid to definitions. Case management, for instance, is allowable in many federal sources but service definitions or components are not uniform across agencies or grants.

All integrated services systems or family drug treatment courts operate most efficiently if there is one person who acts as the conduit of information between the judge and the service agencies. This position is described as the court coordinator. Job responsibilities include case management, service coordination, information gathering, and fact checking along with case admission and assignment. While the ideal is to have funds to hire someone for this position, for planning purposes research the following strategies and resources to identify what you have and can do to “make it happen:”

- I. Is there a local agency or group of agencies that can assign a full or part-time person as court coordinator:
 - a. A local agency or group of agencies may have a client base that will be best served by a family drug treatment court.
 - i. If so, reassignment of staff resources may be both cost effective and improve client outcomes.
 - ii. Local agency may have underutilized program funds that can be assigned to a family drug treatment court.
 - iii. Can this position be shared between two or more persons?
 - iv. Agency or agencies may have contractual or other mandates that promote or require active participation in Family Drug Treatment Courts.
 - v. Canvas and review resources of: substance abuse treatment agencies, OSAR’s, CPS offices and MHMR centers.
 - vi. Are there community volunteers or paraprofessionals that can be utilized to help support clients and reduce workload of a case coordinator.
2. Review staff: family ratios:
 - a. Minimum and maximum number of families per court.
 - i. Analyze the cost efficiency of a half-time and a full time court coordinator and court.

1. What are the maximum & minimum numbers of families for a full or part-time court?
 2. Can forms, formats and procedures be implemented that will increase the number served through efficiency of information dissemination and coordination?
3. Other costs:
- a. Urine testing: who, how much & when
 - b. Office supplies
 - i. Is this a cost that can be shared by participating agencies?
 - ii. If supplies to be purchased, which agency has the best purchasing power?
 - c. Office space
 - i. Can this be “donated?”
 1. Does the County or another agency have a match requirement that can be met through provision of space?
 2. Is there available space that can be utilized at no cost?
 - d. Equipment
 - ii. Can care coordinator utilize existing phone, copying and computer equipment

Leveraging, sharing and reassignment of personnel and resources will demonstrate the ability and commitment to service coordination and integration of the planning group. This, in turn, ensures both cost efficiencies and provides solid justification when requesting funds from public or private sources. That is, identify integrated funding match capabilities before asking outside sources for dollars.

Second Principle: Good data is essential

For marketing, proposal writing, budgeting and policy impact purposes always provide current data on: how many have been served, who they are, what services were provided and the outcomes for the families. Evaluation reports on impact, outcome and fiscal impact are the foundation for long-term financial support and sustainability.

The implementation of universal basic evaluation questions, data sources and measures will provide a base for state level aggregate data for planning and policy purposes. Local implementation of universal basic evaluation plans and systems will provide court specific information for comparative analysis with other courts and quality improvement as well as local marketing, policy development and planning. During planning and start up gather your background data: number of families with substance abuse and related problems, outcomes of those families, demographics on all family members including age, gender, employment, education, presenting drug, race and ethnicity. This data describes who will and do serve.

Demographic data is the foundation for process evaluation, quality improvement, outcome and impact evaluation. Demographics will identify who the program best impacts, procedural problems, and points where families drop out, relapse or fail to move forward. Review the model data based evaluation plan provided in Appendix J and define local evaluation needs and resources, including:

- Identifying data sources and persons responsible for recording and reporting the data
- Establishing guidelines and procedures to review data and process information
- Establishing guidelines and procedures for local data sharing
- Identifying the person(s) responsible for compiling data and providing reports to state and local level entities

- Establishing your cross system quality improvement team
- Develop procedures for team to provide feedback and direction to each system and across systems

Principle Three: Marketing is never-ending and all inclusive:

Marketing is an on-going, continuous process of informing, educating, selling and engaging the public, service providers, policy makers, judges, lawyers, CPS, TX CASA and, most importantly, families. Marketing is really to targeted groups and audiences and includes web sites, brochures and fliers. Include schools, Workforce Centers, doctors' offices and hospitals. Initiate reports to County Commissioners and invite key persons to an information briefing.

Try to maintain a constant level of community awareness. Intermittent public information via the media will not have the same impact on policy makers, fund sources, families, agencies or courts as a steady stream of information. Make the family drug treatment court an institution and a community wide effort.

1. Develop a name for your group and court
 - a. Adopt vision and mission
 - b. Adopt guiding principles
2. Develop brochures, web page, parent information manual and other marketing materials
 - a. Disseminate marketing materials
 - b. Review and update materials bi-annually

Principle Four: Be transparent.

Be open and honest with everyone, including the families, about mistakes, barriers, and gaps. Treatment and recovery require honesty on the part of the client and the provider – so does the quality and success of your family drug treatment court. Building in honesty and open discussion of problems and mistakes will improve client engagement and retention as well as outcomes. Utilize process evaluation to identify and track resolution of problems and barriers.

Adopt “no blame and no shame” policy that includes all participants and systems.

- Conduct case review and problem identification analysis on a review of 30 or 60 day closed cases.
 - Are there service differences between reunified families and those who dropped out or were dropped?
 - If so – what are those differences?
 - Timing of drop-out: is there a point at which most drop outs occur?
 - Is there a greater loss related to any one service gap?
 - What services do all families receive?